TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ERWIN CRUZ, MD

Respondent Name
PROTECTIVE INSURANCE CO

MFDR Tracking Number
M4-18-0259-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
SEPTEMBER 29, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $288.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel maintains the requestor…is not entitled to reimbursement for CPT code 97799(-MR) billed on a CMS-1500 paper billing form for date of service 10/10/16 based on failure to timely submit a complete medical bill in accordance with health care provider billing rules…Per the requestor's fax confirmation information listed at the top of the CMS-1500 labeled 'Proof of Receipt by Carrier', Genesis Medical Management Solutions utilized a transposed fax number 371-715-9639 for submission of the medical billing in question. The correct fax number for the carrier is 317-715-9639. A complete medical bill was received on 02/07/17, 118 days after the date on which the health care services were provided to the injured employee."

Response Submitted By: Corvel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 10, 2016	CPT Code 97799-MR (X4)	$288.00	$288.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. Texas Labor Code §408.0272, effective September 1, 2007, provides for exceptions for timely submission of a claim by a health care provider.

3. 28 Texas Administrative Code §133.20, effective January 29, 2009, 34 *Texas Register* 430, sets out the procedure for healthcare providers submitting medical bills.
4. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
5. 28 Texas Administrative Code §134.230, effective July 17, 2016 sets out the reimbursement guidelines for medical rehabilitation programs
6. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - 29-The time limit for filing claim/bill has expired.
   - W3-Appeal/reconsideration
   - 97A-Provider appeal

Issues

1. Is the respondent's denial of payment supported?
2. What is the applicable fee guideline?
3. What is the appropriate reimbursement for CPT code 97799-MR (X4)?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the services in dispute based upon reason code "29-The time limit for filing claim/bill has expired."

   Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

   28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

   The respondent contends that reimbursement is not due because "…information listed at the top of the CMS-1500 labeled 'Proof of Receipt by Carrier', Genesis Medical Management Solutions utilized a transposed fax number 371-715-9639 for submission of the medical billing in question…The correct fax number for the carrier is 317-715-9639."

   A review of the submitted documentation finds fax confirmation report dated October 26, 2016 that supports bill was sent to fax #1(317)715-9639. The division finds that based on these reports the bill was submitted within the 95 day deadline to the respondent; therefore, the respondent's denial based upon reason code "29" is not supported.

2. The fee guideline for medical rehabilitation services is found in 28 Texas Administrative Code §134.230.

3. 28 Texas Administrative Code §134.230(1) states "Accreditation by the CARF is recommended, but not required. (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the maximum allowable reimbursement (MAR). (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

   The requestor billed 97799-MR; therefore, the disputed program is non-CARF accredited and reimbursement shall be 80% of the MAR.

   28 Texas Administrative Code §134.230(4) states, "The following shall be applied for billing and reimbursement of Outpatient Medical Rehabilitation Programs.
   (A) Program shall be billed and reimbursed using CPT code 97799 with modifier "MR" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $90 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

A review of the submitted medical bill indicates the requestor billed for 4 hours; therefore, 80% of $90.00 = $72.00 X 4 hours = $288.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $288.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $288.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/8/2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.